New Hampshire

Receptor Selective NSAID Medications

NH Medicaid Prior Authorization/Non-Preferred Drug Approval Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

SECTION I: Patient Information and Medication Requested

Name: (Last, First) _____ NH Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Directions:_____ Length of Therapy: _____

SECTION II: Clinical History

1. Patient's diagnosis: _____
2. Is the patient 75 years of age or older? ☐ Yes ☐ No
3. Does the patient have a sulfonamide allergy? ☐ Yes ☐ No
4. Did the patient fail two or more receptor selective NSAID medications, one being a high affinity NSAID, e.g., Lodine® (Etodolac), Feldene® (Piroxicam), Voltaren® (Diclofenac) or Dolobid® (Diflunisal)? ☐ Yes ☐ No
5. Was the patient intolerant of:
   - one receptor selective NSAID medication? ☐ Yes ☐ No
     If Yes, check all that apply: ☐ Edema ☐ GI Symptoms ☐ Failure to control pain
   - a second receptor selective NSAID medication: ☐ Yes ☐ No
     If Yes, check all that apply: ☐ Edema ☐ GI Symptoms ☐ Failure to control pain
6. Indicate which of the following apply:
   Previous history of a GI bleed ☐ Yes ☐ No Date: __ __/__ __/__ __ __ __
   Current use of oral corticosteroid ☐ Yes ☐ No
   Peptic Ulcer Disease ☐ Yes ☐ No
7. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

SECTION III: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____

☐ Age specific indications. Please provide patient age and explain: _____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference: _____

☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

SECTION IV: Prescriber Information

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider